DIVISION OF CHILD MENTAL HEALTH SERVICES
ADMISSION TO MENTAL HEALTH OUTPATIENT SERVICES
☐ New Case ☐ Reopened Case

Date	Agency
Therapist Name	Telephone
	FAX

Client Name	DOB

Address	County K S NC Other	Telephone #1
City/State/Zip	SSN	Telephone #2

Referral Date	Admission Date

RACE
00 American Indian
01 Alaskan Native
02 Asian or Pacific Islander
03 Black/African American
04 White
05 Mixed - Black/White
06 Not of Hispanic or Haitian origin
06 Mixed - Asian/Black
07 Mixed - Asian/White
08 Other

ETHNICITY
01 Hispanic - Mexican
02 Hispanic - Puerto Rican
03 Hispanic - Cuban
04 Other Hispanic
05 Haitian
06 Not of Hispanic or Haitian Origin

GENDER
01 Female
02 Male

LEGAL CHARGES
01 No charges
02 Misdemeanor charges pending
03 Felony charges pending
04 Probation after conviction/misdemeanor
05 Probation after conviction/felony

CLINICAL ELIGIBILITY

List all numbers Checked on EPSDT. Separate with commas	Child's Problems Current _____ _____	Child's Problems Past _____ _____
	Problems in Child's Environment - Current _____ _____	Problems in Child's Environment -Past _____ _____

FINANCIAL ELIGIBILITY

Income Source: Mother		Annual Income		Insured	☐ yes ☐ no
Income Source: Father		Annual Income		Insured	☐ yes ☐ no
Insurance Covers Client ☐M ☐ F ☐ Both ☐ No					
Company			Policy No.		
Policy Holder Name					
Relationship to Client			Is this the primary coverage? ☐ yes ☐ no		
Amount Insurance Will Pay Per Hour/Session			If more than one policy exists please fill out an additional form for each policy in effect.		

Medicaid Available to Client ☐ yes ☐ no ☐ Application in progress		
Medicaid No.	MCO	
Family Size	Annual Household Income	Fee per Session to be Paid by Family

FLUENCY IN ENGLISH

CLIENT	MOTHER	FATHER
01 Fully Fluent	01 Fully Fluent	01 Fully Fluent
02 Partially Fluent	02 Partially Fluent	02 Partially Fluent
03 No Fluency	03 No Fluency	03 No Fluency
04 Sign Only	04 Sign Only	04 Sign Only
Language_____	Language _____	Language _____

EDUCATIONAL STATUS

Grade Completed _____ Now in Grade _____ Name of Current School _____

If not in school now, check one of the following:
☐ under school age, not in school yet ☐ expelled ☐ withdrew
☐ other, explain _____

EDUCATIONAL CLASSIFICATION

01 Regular Education
02 Autism
03 Deaf/Blind
04 Hearing Impairment
05 Learning Disability
06 Mental Handicap
07 Physical Impairment
08 Serious Emotional Disturbance
09 Speech/Language Impairment
10 Visual Impairment
12 Pre-School Speech Delay
13 Developmental Delay

SCHOOL DISTRICT

01 Appoquinimink
02 Brandywine
03 Caesar Rodney
04 Cape Henlopen
05 Capital
06 Christina
07 Colonial
08 Delmar
09 Indian River
10 Kent Co. Vo-Tech
11 Lake Forest
12 Laurel
13 Milford
14 New Castle Co. Vo-Tech
15 Red Clay Consolidated
16 Seaford
17 Smyrna
18 Sussex County Vo-Tech
19 Woodbridge

RESIDENTIAL ARRANGEMENT

01 Both Parents/Guardian
02 Single Parent/Guardian
03 Parent and Step -Parent
04 Relative/DFS Arranged
05 Relative/Family Arranged
06 Foster Family
07 Group Home
08 DCMHS Residential Treatment
09 DYRS Residential
10 Other Institution
11 Other than above, specify
_____

PARENTAL RIGHTS

01 Parents, or by court order, other
02 Mother only
03 Father only
04 DFS
05 YRS
06Other,specify_____
_____

CLIENT MARITAL STATUS

01 Never married
02 Now married
03 Separated
04 Divorced
05 Widowed

Is client pregnant?
☐ yes ☐ no

Does client have children now?
☐ yes ☐ no

REFERRAL SOURCE

REFERRAL FROM TRUANCY COURT ☐ **YES** ☐ **NO** **(One must be checked)**

Write 1 next to first caller. Write 2 next the second caller if any. Write 3 next to the person/agency that recommended the call.

___ Family
___ Court/YRS
___ School system/DPI
___ DFS
___ DCMHS Mobile Crisis
___ Other Social Service Agency
___ DCMHS Central Intake
___ DCMHS Clinical Coordinator
___ Primary Care Physician
___ MCO _____
___ other, specify _____

___ General Hospital
___ Psychiatric Hospital
___ Private MH practitioner
___ Group Home
___ MH Residential
___ SA Residential
___ DCMHS Outpatient MH
___ DCMHS Outpatient SA
___ DCMHS Day MH Day Treatment
___ School Wellness Clinic

I understand that I am applying for DCMHS outpatient services which may cost up to $110 per hour for individual/family sessions, $35 per hour for group sessions and $165 per hour for psychiatry. I attest that the information listed above is correct to the best of my knowledge. I consent to the sharing of information between the Division of Child Mental Health Services and the treatment provider for funding authorization, treatment planning and monitoring.

_____ / /
Signature Parent(s)/Legal Guardian/Custodian (Circle One) Date

DCMHS/EPSDT Screen problems to be listed on the Treatment Plan:

1._____

2. _____

3._____

DSM-IV Diagnosis Upon Admission:

Axis I (Primary)	Code:
Axis I (Secondary)	Code:
Axis II:	Code:
Axis III.	Code:
Axis IV:	Code:
Axis V:	